Biological
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Serials

The Maritime medical news
v. 18 - 19, no. 3-5
(1906-07)

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THE

MARITIME MEDICAL NEWS

A MONTHLY JOURNAL DEVOTED TO MEDICINE & SURGERY

Biological & Medical Serials

VOL. XVIII HALIFAX, NOVA SCOTIA, APRIL, 1906. NO. 4

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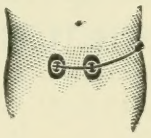

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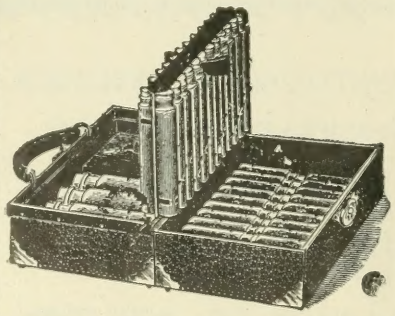

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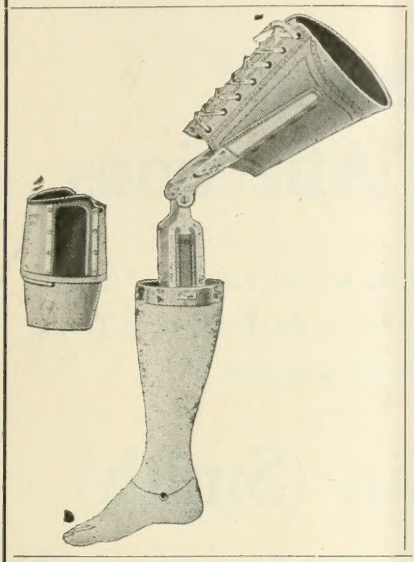

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THE MARITIME MEDICAL NEWS is a monthly magazine devoted to the interests of the medical profession. Communications of general and local professional interest will be gladly received from friends everywhere. Manuscript for publication should be legibly written in ink (or typewritten, if possible) *on one side only* of white paper. All manuscripts and correspondence relative to letter press should be addressed to The Editors, MARITIME MEDICAL NEWS, P. O. Box 341, Halifax, N. S.

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THE
MARITIME MEDICAL NEWS

VOL. XVIII., *APRIL, 1906*, NO. 4.

British Medical Association. From what announcements we have yet seen with reference to the coming meeting of the British Medical Association at Toronto, no account appears to have been taken of the Maritime Provinces as a constituent part of Canada. Of course the summer steamer arrangements make Quebec and Montreal the commonest ports of landing, but it might not be amiss to call attention to the fact that landing at Halifax or St. John is not an impossibility, and that the selection of either of these ports would permit our distinguished visitors to see more of Canadian territory than would otherwise be the case. Moreover, these provinces by the sea are really of some importance, and merit at least recognition. We venture to make this assertion in spite of the peculiar absence of Maritime Province names from the long lists of vice-presidents, etc., of sections.

Cerebro-Spinal Meningitis. It seems probable that the clinical picture and prognosis and to some extent the pathology and treatment of Cerebro-spinal Meningitis will be modified in the coming text books of medicine owing to the influence of the recent epidemics, which have presented wide departures from the traditional course familiar to physicians. Dr. A. T. Osborne, professor of therapeutics at Yale, presents his personal views and experience in the *New York Medical Journal*. He takes the stand that it is no more communicable than is pneumonia, and that a large majority of cases do not die. An epidemic of this disease does not start from a focus and widen out, but is widely spread, striking at at once a great many persons who in no possible way could have come in contact with each other. The infection in many cases at least starts in the pharyngeal tonsil, and the pituitary body is the part of the brain first affected. Infection is by lymph rather than blood channels. The meningo coccus is not the only germ to produce the disease. The real cause is unknown. Many cases come about with only the primary first congestion. Although primarily limited to the cerebro-spinal system, there is no disease that can have so many complications and sequelae, but it is not a septicæmic process, and metastatic abscesses are rarely or never seen. Neither

do the lymph glands nor the spleen ordinarily enlarge. The treatment consists in diminishing the congestion if possible and combating acute symptoms as they occur. Diphtheria antitoxin is theoretically unsound and practically a failure. Spinal puncture is indicated where there is cerebral pressure but is not a curative measure. Ergot in conjunction with morphine is strongly recommended to quiet cerebral excitement and pain. Ice, ergot, and morphine, Dr. Osborne believes, is the treatment that will save, and has saved, many patients from death from this disease.

Gonococcus Infection. The formidable character of the gonococcus infection, and the difficulty or, in many cases, impossibility of cure, are becoming more impressed on the medical profession. The necessity for a better understanding of the results of the disease by the laity, and of a deeper sense of responsibility on the part of the physician is set forth by Dr. Clark, of New York, in the *New York Medical Journal.* It is now recognized that gonorrhœa has invaded practically every tissue of the body, and that no class of society is immune. It is estimated that seventy-five per cent. of the adult male population are infected. In nine out of ten cases of anterior urethritis, the disease becomes posterior, with danger of rendering its victim indefinitely infectious, or perhaps sterile. Prostatitis is a most serious complication, accounting for chronicity, resistance to treatment, prolonged infectiveness and sexual neurasthenia. Once posterior, concerning its course and its cure it is impossible to speak with certainty, and the man who marries with an uncured gonorrhœa will almost certainly infect his wife. If we compare, from a social point of view, gonorrhœa with syphilis, gonorrhœa is to syphilis as 100 to 1, not only from the standpoint of the number of persons attacked, but also of the gravity of the lesions and their perpetuity. It is probable that every prostitute is gonorrhœal and a source of danger. In this class are to be included many women working in stores, in factories, as servants, or in theatrical companies. This evil has its origin in ignorance. The key to the situation is the light of true knowledge, and the source of this light is the medical profession.

Prevention of Seasickness. Ocean travel is becoming so general that the question of seasickness is pressed more and more strongly upon the medical profession, and it must be admitted that the failure to cope with this distressing affliction is somewhat of a reproach to medical science. Many "sure cures" have been advocated, but these have all failed to meet more than a few cases. A method

which has at least the merit of simplicity is that advocated by Eugene Wolf (*Deutsche med. Wochenschrift*, January 18th,) who asserts that seasickness is accompanied by marked anæmia of the brain, and that its treatment consists in the application of very hot compresses to the head. He claims invariably good results from his treatment when carefully carried out. Towels wrung out of very hot water are applied to the forehead and firmly bound, by the exercise of as much tension of the binder as the patient can permit. Frequent changes are necessary. Very soon a feeling of relief is experienced, usually within an hour. The appearance of thirst is an omen of good, but the patient should remain recumbent until he is really hungry. Then the first food is allowed—a little toast and hot, weak tea without milk or sugar. Two hours later the patient may be allowed to go to the table.

There should be no attempt made at "fighting-off" the seasickness, but the recumbent position should be assumed at once when the first qualms are experienced. Dr. Wolf insists upon the efficacy of this treatment if faithfully followed out.

In this connection it is interesting to note that the League Against Seasickness, will, it is stated, charter a steamship while the medical congress is held in the coming April. During a trip from Hamburg to Portugal, touching on the way at Antwerp, Dover, Cherbourg and Panillac, the many methods which have been advocated for the cure of seasickness will be tested.

*

Management of Labour Cases. In a recent article by Horrocks in the *British Medical Journal*, a strong appeal is made for non-interference in normal labour cases. He sums up as follows:—

1. Labour is a natural process and should be looked upon as such.
2. 90% to 95% of cases are normal.
3. Patients should not be examined, per vaginam, more than once unless absolutely necessary.
4. It is detrimental to terminate normal labour by forceps or manual interference, merely to save time.
5. Chloroform should not be used merely to alleviate labour pains.
6. Non-interference with the placenta is recommended, even at the expense of considerable time.
7. The routine application of germicides to the eyes of every new born child is unnecessary.

If we were to follow the articles of many of the present day writers we should almost certainly be led to the belief that many of nature's best efforts on our behalf are dangerous and destructive.

Struggling through this quagmire of fanaticism we are relieved at times to strike the solid ground of common sense.

Many of the pseudo-scientific articles of to-day are nothing more than blatant advertisements by the authors of methods intended to overcome imaginary difficulties. In contrast to these, Mr. Horrock's article stands out as a useful, practical paper which cannot but appeal to the general practitioner. His conclusions are based upon his immense experience at Guy's Hospital where he handles some three thousand cases annually.

Intravenous Infusions According to the *American Journal of Surgery*, when a single intravenous infusion is required, as, for example, to combat the shock of hæmorrhage, there is no need for the solution to contain other salts than sodium chloride. But when successive infusions are likely to be needed, as in the treatment of toxæmic conditions, the solution should be made to approach more nearly to the composition of blood serum. For such purpose the following solution is suggested: Sodium chloride 0.9, potassium chloride 0.03, calcium chloride 0.02, water 100.

Vomiting after Anæsthesia According to T. D. Luke, (*Edinburgh Medical Journal*,) ether causes nausea and vomiting coming on soon after anæsthesia, being severe, but lasting only a short time. Chloroform causes nausea and vomiting much later and lasting longer. Purging the day previous to anæsthesia is injurious, and if it should be necessary this should occur at least two days before operating. Severe fasting is not advisable. Milk diet should be avoided for a day or two following anæsthesia, since ether and chloroform produce a temporary hyperacidity. The patient must remain quiet for a few days and receive a rectal enema (one-half litre of normal saline solution) immediately after narcosis, to hasten the elimination of the anæsthetic and reduce the thirst. The mouth should be washed repeatedly with a mild astringent. Warm water may be taken soon after an anæsthetic. No drugs are of benefit to prevent vomiting.

Temperature During Menstruation. E. Franck, (*Berliner klin. Woch.*) reiterates his contention that fever during menstruation is indicative of a morbid process somewhere within the body. It is especially likely to be due to a tubercular process, and, if it cannot otherwise be accounted for, calls for anti-tubercular treatment.

From *Practical Medicine*, published in Delhi, India, we excerpt the following, which we suppose must indicate that even in a country so remote as India there are men who have peculiar methods: "When the patient dies on the operating table, blame the anæsthetist; when the case goes

septic, blame the nurse; when the patient recovers, take all the credit to yourself."

Unpleasant Effects of Veronal. Abstracting an article by Kress, in one of the German journals, the *British Medical Journal* (November 2, 1905) says that Kress finds veronal to have many disadvantages, including sickness and delirium, rash, giddiness, headaches, sweating, collapse, motor restlessness, orthotonus and tetanic twitchings, cumulative action and prolonged sleeplessness, comatose condition, and in one instance death. Seemingly the drug had been used continuously in the cases showing the more markedly unfavourable symptoms.

Incompatibilities in Prescriptions. Never prescribe dilute hydrocyanic acid or cyanides, bromides, chlorides, iodides, etc., with mild chloride of mercury. Tr. digitalis in an aqueous vehicle should not be kept for any length of time. Chloral hydrate in a mixture of alcohol and water forms an alcoholate which floats on top of the mixture. Old sp. æth. nitrosi liberates iodine from iodides, due to acidity often. Chlorates in solution with iodides form iodates with some free iodine. Lime water becomes cloudy with carbonates. Antipyrin is incompatible with phenol, alum, syr. ferri iodi, borax with gelatine and acacia, and can be equalized by adding a small quantity of sugar. Chloral added to an alkali forms chloroform. Bismuth subnitrate forms a red compound with iodine, and liberates CO_2 in solution containing bicarbonates. Strong acids always form ethers with alcohols. Ichthyol is incompatible with acids, alkalies, etc. — *Medical Standard.*

The Curse of Modern Civilisation. The unnatural tension, wear and tear, that are incident to the high pressure under which we are living, are driving a multitude of men and women to resort to sedative drugs to soothe and calm their irritated and hypersensitive nerves. The drug habit is becoming so alarmingly prevalent that it is already being regarded as a national calamity. The number of morphine, cocaine, and kindred drug fiends is enormous. In addition to the prescription of physicians, and to legitimate sales, the inhabitants of one small New England town last year used three million doses of opium. As the divine declaration, "Whatsoever a man soweth, that shall he also reap," is as unerring in its operation as is the law of gravitation, bad results must be sure to follow such a frightful sowing.—*Good Health.*

Flies in the Sick Room. The suggestion is made in the *Pacific Medical Journal* that a saturated solution of oil of lavender in absolute alcohol used as a spray

by an atomizer on the pillow and bedding, is an efficient protective against the annoyance of flies and mosquitoes in the sick room. Houses and places infested with ants, it is claimed, may be readily rid of these pests by placing strips of blotting paper soaked in peppermint oil in their haunts. This is an easy and simple remedy worthy of a trial.

The lowest death-rate in the large towns of Europe is that of The Hague, where, from a population of over 160,000, the death-rate is about 9.1 per 1,000.

Pancreatic Activity. A test for this is provided by *The Practitioner* (July, 1905). If a drachm of salol be given in divided doses during 24 hours, carbolic acid will appear in the urine, for the reason that the salol is broken up by the alkaline pancreatic juice in the small intestine. But if no pancreatic juice is secreted the salol remains unchanged, and no carbolic acid can be detected in the urine. The most convenient tests for carbolic acid in the urine are: (1) Add to the urine a few drops of liquor ferri perchloridi; if the acid is present a violet color results. (2) By adding to the urine a few drops of bromine water a yellow crystalline precipitate (tribromo-phenol) is produced. (3) If a small quantity of bleaching powder and a little ammonia are added, the urine, on being heated, takes on a blue color. (4) The addition of Millon's reagent (acid nitrate of mercury) will produce a bright red color. One may thus diagnose obstruction to the out-pouring of the pancreatic juice into the duodenum.

Diabetes. James Tyson, in the *Therapeutic Gazette* for December, states that while there has not been much added to our knowledge of the treatment of diabetes of late years, its results on the whole may be considered more satisfactory in the last decade than prior to this period. It is needless to say that the dietetic treatment of diabetes mellitus is far more important than the medicinal, yet a proper hygiene is only second in importance. He knows of but one drug which is capable of reducing the quantity of glucose in the urine of a case of diabetes mellitus, the drug being opium. While all preparations of opium have this effect, gum opium is probably the most efficient, and codein has become the most popular preparation chiefly because its use is unattended with unpleasant effects, although it is more expensive and less efficient than other opium preparations. It probably acts by quieting nervous irritability, but other drugs with similar action have failed, and the use of adrenalin has led to no practical results. He has no confidence in any other drug except arsenic, believing that the continuous use of small doses of Fowler's

solution does favorably influence the course of a diabetes mellitus, but whether as a tonic or a promoter of oxidation he does not know. The alkalies are useful in diabetes not so much as remedies, as a protection against its more serious complications, the acid intoxications; he thinks it a very good idea to have a diabetic patient more or less constantly under the use of alkalies, either in the shape of the citrates or the carbonates of potash, or the natural alkaline mineral waters. For the complications, the most important treatment is that directed to the disease itself. This relieves the pruritus, the eczemas, the tendency to boils, although the usual local remedies for these conditions may be employed. For diabetic coma, the indication is to alkalize the urine as quickly as possible, and while temporary benefit is obtained from the injection of salt solution, or better, weak alkaline solution, he has never seen any permanent benefit from its use.—*Cleveland Medical Journal.*

The Sanitarium Movement in New Brunswick.

As already mentioned in THE NEWS, an influential deputation waited upon the Government of New Brunswick and discussed the matter of the establishment of a Provincial sanitarium for the treatment of tuberculosis.

A carefully prepared address was read, one which was drawn up by a committee of the New Brunswick Medical Society. The committee had held numerous meetings and gone into the subject thoroughly, after receiving information bearing upon the matter from various sources.

It now remains for the Government to announce the line of action it proposes to take.

Full information regarding the great importance of such an institution, the results of institutional treatment and an estimate of the cost have been set forth, so that the Government has been supplied with the facts necessary to come to a decision.

But this is not the first occasion upon which this subject has been brought to the attention of the Province. The credit must be given to Dr. Wm. Bayard, then chairman of the Provincial Board of Health, for first moving in the matter.

It was as far back as March, 1901, Dr. Bayard addressed an admirably written statement to the Premier in which the establishment of a sanitarium was strongly urged. This paper is still worthy of close attention and hold strue today.

Dr. Bayard was also prepared to collect a large sum of money to aid in the object.

Surely then some tangible result will follow these well directed efforts. It is for the New Brunswick Medical Society and Boards of Health to persistently urge the matter until the desired object is attained.

The Proper Housing of the Labouring Classes.

The medical profession has long taken an intelligent interest in the problems connected with the housing of the poor, and the general uplifting of the labouring classes. This interest has in many cases led to the most practical of reforms, as the advance of sanitary science abundantly proves. The great improvement in the public health, and the increased longevity of the people, are due in a large measure to our work.

The profession has long recognized the difference between the health and robustness, the fighting powers against disease and the chance of recovery, of those who live in good, well-ventilated houses with sanitary conditions of the best, and those who are unfortunate in their surroundings in ill-ventilated, unsanitary and overcrowded apartments. The question of health appeals especially to us as physicians, our aim being to save life, and to improve its efficiency, from childhood up to old age.

But there are other questions of as great importance, to which we do not close our eyes. Mr. Jacob A. Riis, the great social reformer says: "The family home is the basis on which our modern civilization rests." The whole subject of morals is at once introduced, the overcrowded, unsanitary tenement leading to pauperism and crime. The investigation of the slums of great cities shows that Tennyson did not write without a reason:

> "There amid the glooming alleys Progress halts on palsied feet,
> Crime and hunger cast our maidens by the thousand on the street"

The city of Halifax enjoys a bad pre-eminence in the condition of the homes in which the poor and the working classes are compelled to live. The city was intended by nature to be a city of stone, upon which it rests, and by which it is everywhere surrounded. Instead of that, the houses are of wood which requires constant repair, and an abundant supply of paint. These are seldom in evidence even in the better houses, while in the poorer houses they are practically unknown.

It is therefore with great pleasure that we learn of a movement which has as its object the permanent improvement of the "upper streets" of Halifax, which have long been a disgrace to the city, and a potent factor in the spread of disease and crime. The proposition before the promoters, which is but the beginning of their plan, is to purchase a number of lots, if possible a whole block, to raze the present buildings, and to erect tenements of a substantial nature, of brick, cement, or cement blocks as may be found advisable. The most advanced sanitation would be introduced, and every regard given to convenience and comfort. The rental would be about the same as is now

paid for the most wretched accommodation. There would probably be a cheap restaurant in the block, and two or three stores. The appearance of the buildings would be imposing from an architectural standpoint, one reason among many being that the block would be quite large, and afford room for a good effect, especially if built in cement blocks. The promoters are considering the question of making the building quite fireproof, with all the floors laid in cement, and the roof of the same material. There will be good facilities for bathing. In the rear there will be a nice playground under the best conditions of cleanliness and fresh air.

The scheme was recently laid before the Halifax and Nova Scotia Branch of the British Medical Association, in the hope that the members of the medical profession would not only endorse the movement, but furnish advice and counsel to the promoters. The project was submitted by the Rev. Dr. Armitage, who proved himself to be thoroughly conversant with all the details of the subject, and whose intelligent and earnest interest in this matter must be peculiarly gratifying.

The Branch has reported most favourably on the plans proposed, and has also issued the most formidable indictment which has yet been made of the criminal neglect of the people of Halifax, in that they have allowed such conditions as are indicated by the report of the Branch's special committee to exist. The civic conscience, which has long been quietly sleeping, has at last been aroused.

The promoters, who include some of our best and most public spirited citizens, are seeking legislation which will allow them to proceed in their work of reform. This will no doubt be given by the legislature during its present session, as the movement has the endorsement of the Laws and Privileges Committee of the city council.

The plans, as far as they have been outlined, are along the most practical lines, and while aiming at the hygienic and moral benefit of those who will take advantage of the buildings, yet look for a fair financial return to the builders or more properly the investors. The aim is only indirectly philanthropic and charitable, for the purpose is not to offer lower rents, which might tend to lower wages, but to furnish the comfort of a home with good sanitary surroundings, and to furnish more for the money than under the present unsatisfactory conditions.

It will mean, we are confident, much for Halifax, not the least being a considerable saving of life. Joseph Chamberlain, who was a chief mover in kindred reforms in Birmingham, claims that that city has, since the inception of such reforms, saved 3,000 lives per year,

and that the death-rate was reduced from 26.8 per 1,000 in 1874 to 19 in 1888. It was stated at the meeting of the Branch of the British Medical Association, to which reference has been made, by one of our local physicians, that the death-rate of Halifax is 25 per 1,000, which he declared is the highest on the American continent. If this is true, instead of hiding so appalling a fact, there should be a vigorous sanitary campaign, which should be kept up until Halifax becomes, as she should be, the healthiest city in North America.

The Patent Medicine Bill.

At a recent meeting of the Halifax and Nova Scotia Branch of the British Medical Association, a committee was appointed to arrange, if possible, to secure legislation to control the sale of patent medicines. Acting in conjunction with Dr. Ellis, M. P. P. of Guysboro', a bill was prepared substantially upon the same lines as the Ontario bill, and submitted to the Nova Scotia Legislature. The salient features of the bill were that it required the formula of each medicine to be printed upon the label of the bottle, and that all preparations containing more than a stated percentage of certain poisonous drugs should be labelled "Poison."

The introduction of the bill was the signal for instant and well organized activity on the part of the proprietary medicine people. As was expected, the lay press, so heavily subsidized by various patent medicine concerns, thundered out against the medical profession and showed intimate acquaintance with the arguments of the patent medicine vendors, with seemingly a complete misconception of the motives which inspired the introduction of the bill. The "Morning Chronicle" published a violent editorial entitled, "Kill This Bill," the "Acadian Recorder" also charged strongly against it, and the "Halifax Herald" likewise did the bidding of its subsidizers. In the case of the latter journal, carelessness in the mechanical department permitted delay in the publication of the editorial until the day after the bill was killed in the legislature, and an apology to the patent medicine people became necessary. All three journals intimated that the bill was solely in the interests of the medical profession, and the doctors were charged with organization for purely selfish purposes.

Of course the bill was killed. We have no special comment to make. From the pecuniary point of view, the medical profession are distinctly the gainers. No measure has ever been advocated for the general weal by physicians, which has not been opposed by the laity until, after years of preachment and demonstration, the advantage has become so conspicuous that the dullest have been able to appreciate it. So it will doubtless be in the case of the patent medicine business. But this continuous suspicion of the physician's motives, and these constantly reiterated charges of self interest and conspiracy, are becoming galling beyond the point of endurance. The public really deserve nothing better of us than to be left alone. Were it not that our path of duty is so clearly marked and our sense of responsibility so persistently kept active, we might easily be persuaded to fall into the easy way of believing that "whatever is, is best."

THE PUBLIC HEALTH ACT OF NEW BRUNSWICK.

By J. W. DANIEL, M. D., M. P., etc.,
St. John, N. B.

(It is our purpose to publish a series of articles dealing with matters which concern the physician both as a citizen and as a practitioner. The following article, the first of the series, is from the pen of one well qualified to discuss a subject in which every physician should be deeply interested. In future issues, the Public Health Acts of the other two maritime provinces will receive consideration.)

THIS Act was passed in 1898, and there have been some few amendments since.

It provides for a Provincial Board consisting of not more than seven members, of whom one is Secretary. The members are all appointed by the Lieutenant-Governor-in-Council for a period of three years, and are eligible for re-appointment. At least four members must be registered medical practitioners. The Chairman is appointed by the Lieutenant-Governor-in-Council, and the services of all the members except the Secretary are entirely honorary, they receiving only their travelling and other necessary expenses while engaged on business of the Board.

The Secretary is appointed by the Lieutenant-Governor-in-Council and holds office during pleasure, is paid an annual salary, and is the Chief Health Officer of the Province.

The Provincial Board has power to make rules and by-laws regulating its own business.

The Secretary keeps a record of the transactions of the board, communicates with foreign and local boards, with municipal and other public bodies, etc., and performs such other duties as may be assigned by the Lieutenant-Governor-in-Council.

The Provincial Board has supreme control in health matters. It takes general cognizance of the interests of health among the people; makes profitable use of information available as to deaths and sickness; makes sanitary investigations and enquiries regarding causes of disease, especially epidemics; causes of mortality; effects of localities, employments, conditions, habits, etc., on health; makes suggestions as to prevention of introduction of contagious and infectious disease; advises Government and local boards of health in regard to public health and disease, and as to location of drainage, water supply, disposal of excreta, heating and ventilation of public buildings, etc. It is their duty during prevalence of epidemics to distribute suitable literature relating to spread of infectious and contagious disease through the press and circulars to local boards of health, municipal councils, schools, etc.

The Provincial Board may send its Secretary or any of its members to any part of the Province to investigate causes of disease or death in special contagious diseases, take evidence on oath, and issue regulations for prevention or mitigation of such epidemic, endemic or contagious diseases. These include regulations for cleansing streets, the cleaning, purifying and disinfection of houses, railway stations, churches, public buildings, steamboats, railway cars and public conveyances, for plumbing and drainage in cities where there is a system of sewerage, and designate city or town in which an inspector of plumbing should be appointed. All these regulations, after approval by Lieutenant-Governor-in-Council, must be enforced by the local board of health, and if local boards neglect or refuse to do so, the Provincial Board may enforce the same at the expense of such local board.

With regard to local boards, the Province is divided into Health Districts and a board is appointed for each district. In cities and towns these boards are composed of five members and in other districts of three, of whom one must be a registered medical practitioner. The Government appoints the chairman of each board, and the municipality the other members; each member is a health officer in his district and may exercise all the powers of a health officer given under the Act.

Local boards may make regulations with regard to public health which after being published in two consecutive issues of a daily paper in the district, or in Royal Gazette, become law and remain so until and unless they are disallowed by the Lieutenant-Governor-in-Council.

Local Boards may appoint a health officer, make regulations for preservation of public health within their district, may enter upon and examine any premises and cause same to be cleaned, etc; may make and declare regulations concerning entry and departure of vessels at different ports, concerning landing of cargoes and passengers, or receiving of cargoes and passengers on board of same may authorize examination and inspection of railway trains entering Province, of passengers and employees, and of freight, may authorize their detention, disinfection, etc., or prevent entry except in accordance with regulations, or may remove from trains, boats or vessels any passenger, employee or other person infected or suspected or liable to communicate disease, and do generally what may be deemed necessary under the circumstances.

In cases of infectious disease the Act places certain duties and responsibilities on the householder. No householder in whose house there is a case of scarlatina, diphtheria, smallpox, cholera or typhus, shall allow any person,

clothing or property to be removed without the consent of local board, and no one recovering from any of these diseases, or nurses in attendance, may mingle with the public until proper precautions have been taken.

The Board also has power to destroy bedding, clothing, etc., when they deem it necessary. There are also special regulations with regard to schools which have become infected.

Health officers may also on written report of a medical practitioner recommending the same, cause any person infected with dangerous contagious or infectious disease to be removed to hospital or other suitable place, but such report must state that removal can be made without danger to life and is necessary to guard against spread of disease. The local board has also ordinary placarding powers.

Householders and physicians meeting with cases of the five mentioned infectious diseases, and also with typhoid cases, must notify the local board.

The power to order compulsory vaccination is retained by Lieutenant-Governor-in-Council, and can only be exercised by local boards after proclamation by that authority.

Provision is made for the payment of the expenses of the board, but the position of the members is entirely honorary.

Such is a brief outline of the provisions of the Act.

Its powers, responsibilities and duties are divided between the Government, the provincial board, the local board, the householder and the practising physician.

The Government retain the responsibility for condition of public health, because they retain the appointment of the provincial board, the chief health officer, and the chairmen of the local boards who are especially clothed with all the powers of local boards in case these latter fail to act. The Government also retains power of ordering compulsory vaccination and they also retain the power of the public purse.

The Public Health Act is a well conceived Act, placing the responsibility where the power is, while great and sufficient power is given to both local and provincial boards, and certain duties are placed on the householder and physician.

The local boards are the important part of the machine. On them devolves the duty of dealing with the emergency as it arises, of acting with vigor and intelligence. They are provided with ample power and in its exercise will often be obliged to shoulder great responibility, frequent misconception, ignorant criticism and even vituperation and abuse. The position is therefore not one that there is any great anxiety or ambition to fill. Frequently the greatest responsibility of all rests upon the physician who is the first to see

the case. If he should be careless about making his diagnosis, or from whatever cause fail to notify the authorities in reasonable time, an epidemic may become started, which before it is overcome may result in the loss of many lives, of thousands of dollars in expenditure, and become the creator of untold distress mental and bodily.

I have always been of the opinion that the physician who is compelled by law to notify cases of infectious diseases should be paid for that service. Our Act is presumably taken from the English Act, but that Act is a permissive or optional Act: that is to say no health district is compelled to adopt it, but where it has been adopted, the district must bear the expense and responsibility as well as the advantage, and among the necessary expenses is the payment to the physician of half a crown (60 cents) for each case he reports. I see no reason why the same practice should not prevail here, and until it does, I am quite satisfied that the public will not reap the full benefit of the Act, and after a somewhat lengthened experience in public health matters I am strongly of the opinion that the country would save money if this act of common honesty were carried into effect.

Another weakness of the Act is the small salary paid to the Secretary of the provincial board, which is not sufficient to allow him to give as much time to the duties of his office as they demand from the chief health officer of the Province. A greater weakness still is the fact that the provincial board have not the appointment of their Secretary, who is also the chief health officer of the Province. He holds office simply at the pleasure of the Government, and is consequently entirely independent of the wishes of the board whose ostensible officer he is. Take for instance the case of a lumber camp in which infectious disease has broken out. The chief health officer visits the camp either of his own motion or by order of the board, places the camp under quarantine and takes other drastic measures necessary under the circumstances. Meanwhile suppose the owner of the camp is an influential supporter of the Government and he brings pressure to bear on the Government to have these regulations modified to a greater degree than the health officer thinks proper or safe, and the Government notifies its official —the health officer—to that effect, what is the position of the health officer under these circumstances? Of course this is only a supposititious case, but the fact that such a thing might happen emphasizes the importance of having the chief health officer appointed by the provincial board whose officer he is supposed to be. Another weakness in the Act is that neither the provincial board nor the chief health officer have

any initiative in the matter of spending money, except as they may be specially permitted by the Government. With regard to the provincial board, its usefulness or otherwise will depend almost entirely upon its personel. If it is composed of active intelligent men interested in public health, with a desire and determination to give the country the benefit of its powers and authority, no fault can be found with it.

It has been suggested that the provincial board might be composed of a representative of the local boards, and it appears to the writer that such a change would be in the interest of public health. There would then be brought to the meetings of the board positive and correct information as to the health needs of every part of the Province, and as the members would be men in the habit of enforcing the regulations in their various districts, the chances are very great that life and activity would be added to the board and its deliberations to a greater extent than at present seem to exist.

Recapitulation :

The Act in its general aspects is a good one. The writer thinks that it might be improved :—

1. By placing the appointment of the chief health officer in the hands of the provincial board of health.

2. By giving the chief health officer a salary sufficient to permit of his giving the whole or at least the most of his time to the duties of his office.

3. Enlivening and broadening the provincial board of health by having it composed of a member from each of the local boards, or, if that might be thought to make the board too unwieldy, giving the right to these members of local boards to be present at provincial board meetings and of voting either as a separate body or in conjunction with provincial board.

4. By paying every practising physician a suitable fee for notifying cases of infectious diseases. This recommendation comes last, but the writer thinks it is of first importance.

One other weakness in the Act is the fact that the local boards have no money on hand to meet epidemics or emergencies. The practice is that local boards every year at a stated time send in to the municipal council an estimate of their expenditure for the year, but this estimate does not provide for anything beyond the ordinary expenditure of the year. It is therefore often the case, especially in rural counties, that the members of the board find themselves face to face with a condition that requires the immediate possession and expenditure of ready money, while they are themselves entirely without funds. Under these circumstances they can only obtain money by getting an advance from a bank on their own personal security, and trust to the debt being paid afterwards by the county council. This is not a position members of boards of health should be placed in, and there is no doubt that members often shrink from accepting any such financial responsibility, with the result that preventable disease may gather headway and spread to a much greater extent than it would if the money or credit were available at the time.

The above are some of the ideas which suggest themselves to the writer who has had some considerable experience in the operation of this Act.

SUB-DIAPHRAGMATIC ABSCESS FOLLOWING OPERATION FOR APPENDICITIS.

By WILLIAM ROCKWELL, M. D.,
River Hebert, N. S.

(Read before Halifax and N. S. Branch British Medical Assoc., Jan. 3rd, 1906.)

I THOUGHT best in reporting this case to give a somewhat detailed account of the whole process leading up to the formation of the abscess.

The patient was a man aged 51 years ; married ; a coal miner by trade, but had also worked at making stone and as a lumberman. His mother is still living and his father died aged 73, probably from phthisis. Brothers and sisters are all healthy. He never was laid up with any sickness. The only thing he ever complained of was some distress in the stomach and at times cramps, but never enough to lay him up, and would not be bothered perhaps for years. He was a temperate man.

The present attack came on June 23rd, 1904, while working in a mine. He was taken with a violent pain and when I saw him at his house had vomited and felt very cold, and the pain was most severe. He did not refer it to any particular region but it seemed all over the abdomen. I gave him a hypodermic of morphia, had also hot fomentations applied ; and after a time pain subsided. The pain then began to locate itself in right side, at or near McBurney's point. After pain had somewhat subsided I proceeded to empty bowels, using divided doses of calomel followed by repeated small doses of Epsom salts and an enema of soap and water. After bowels were emptied pain was somewhat better but still considerable, and there was marked rigidity of muscles over seat of pain. The treatment now consisted of a liquid diet, hot applications and morphia to ease pain. He would not consent to an operation, so the case went on with more or less pain and tenderness for two weeks. His temperature was not high. There was a distinct sausage-like tumour to be made out. On July 8th, two weeks after the beginning of the attack, Dr. Codman, of Boston, saw the case with me. His temperature was about normal and he did not have much pain. The tenderness was not very marked but the sausage-like tumour was still quite evident. Dr. Codman thought he would likely get over the present attack. However, he decided to be operated on and Dr. Codman, assisted by Dr. Steeves and myself, operated on him July 8th. On opening the abdomen there was

found a large quantity of adhesions, and in breaking these up to find the appendix a pus cavity was broken into which contained about two ounces of pus. The appendix was sought for and removed. It was posterior and pointing up towards the liver. The adhesions seemed to extend well up in that direction. Four gauze wicks were placed in the abdomen and wound was left open. He rallied well from the chloroform. He seemed to do well and the wicks were removed on the fourth day. There was not much discharge of pus after the first dressing. The wound seemed to do well and closed up very well at first, but later seemed to remain stationary and looked rather indolent. There was a sinus but no discharge from it.

July 14th.— Complained of slight pain in right side of chest.

July 17th.—Said he felt cold but was so only for short time and he had no chill.

July 18th.—Again felt a little cold.

July 19th.—Pain in right side. Mustard applied; slight chill.

July 20th.—Pain felt in right side when lying on left.

July 21st.—Some pain and perspired profusely.

From 21st to 25th complained of slight pain in side.

July 25th, used hypodermic syringe and drew off some clear fluid. On afternoon of same day I aspirated and withdrew 50 ounces of pus from right side, which was very offensive. It gave slight reaction to a bile test. His temperature up to 17th, after the operation, had not reached, 100° F., and his pulse was not above 96. His temperature during this period, on the average, was about a degree high and he was not very uncomfortable. Once between 17th and 25th his temperature was 102° F. He continued about the same and I aspirated again on the 27th and removed twelve ounces of pus. From the 27th to 30th temperature varied from normal to 99.2° F., when I cut down and removed a section of the eighth rib. There was a large flow of pus which was very offensive. His temperature now continued nearly normal and pulse ranged from 86 to 92. On August 3rd he felt a slight chill but no rise of temperature with it. From this on his temperature was for the most time normal and at no time was there any considerable elevation. On August 17th and 26th there was a very large discharge of pus after an apparent cessation. During all the time after resection of rib, the discharge was profuse, with the exception of periods previous to the 17th and 26th when it had apparently ceased, nor were there any symptoms that could be referred to the retained discharge. After the section of the rib was made he felt well and had a good appetite. Towards the last his appetite failed and there was a

gradual giving out of vital forces, and he died on September 2nd.

The causes of subphrenic abscess in the order of frequency are: Perforating gastric ulcer, upward extension of an appendical inflammation, and duodenal ulcer. Less frequently as causes may be named extension of pneumonic infection, perforation of an empyema through the diaphragm, malignant disease of stomach or liver, rupture of an hepatic, perinephritic or pancreatic abscess, disease of the gall bladder and trauma.

Madyl collected 179 cases from literature, and Lang 173 to which he added 3 new ones. Of Madyl's 179, twenty-three were due to appendicitis. Lang, out of 176 cases of right sided abscess, found 20 due to appendicitis. Weber in 1900 reported 9 cases out of 600 cases operated on for appendicitis by Sonnenburg. Of these 600 cases, 350 had peri-appendical abscess; that is 2.5% of the pus cases had sub-diaphagmatic abscess. Elsberg reports two cases in 91 consecutive appendicitis operations. Kelly states he found the sub-phrenic region affected seven times in 86 operations for appendicitis, although they were not all cases of abscess. In a series of 76 cases reported by Frankel, there was an abscess in or around the appendix in 50 cases, or 68 per cent. In the other 16 cases no details were given. Perforation of the diaphragm occurred in 25 per cent. The total mortality was 40 per cent.

According to Elsberg, subphrenic abscess secondary to disease may occur in one of three ways:

1. As a localization in the right or left subphrenic region of a general systemic infection, the infectious agents being carried to the subphrenic region by the blood current. Here the process is secondary to a generalized infection.

2. As a localized abscess formation in the right or left subphrenic region, a part of a general purulent peritonitis with foci of suppuration in various parts of the abdominal cavity. This variety is infrequent, as the patients generally die before encapsulation of the abscess can occur.

3. As a local process by direct extension or through the lymph channels from disease in or around the vermiform appendix. This is the most frequent variety.

The symptoms of subphrenic inflammation may come on days, weeks or months after the disease of the appendix or the operative measures instituted therefor. Several modes of onset are characteristic:

(a) A few days after the acute symptoms of appendicitis have been relieved and the temperature has fallen to normal the patients complain of pain in the lower part of the right chest, the temperature begins to rise, the area of liver

dullness is somewhat enlarged; there are friction sounds over the hepatic region and tenderness in one or two intercostal spaces. There may be slight or well marked jaundice. Within a few days the pain over the liver becomes less while the signs of fluid become evident.

(b) Before the acute signs of appendicitis have entirely subsided, although the local symptoms are much improved, the daily temperature begins to take on a remittent type, and the patient begins to lose flesh and strength rapidly. These patients look very ill from the beginning. They do not complain of much pain, although they may have tenderness in the lumbar region; the most marked symptom is the rapid loss of flesh and strength. No further physical signs may be discoverable until the bulging of the abscess in the lumbar region is found.

(c) After having recovered from the attack of appendicitis in a satisfactory manner, some of the patients never regain their former health. Without any change in the temperature, respiration or pulse the patient complains of continual slight pain in the right chest. The pain persists for weeks and months, although physical examination and aspiration of the right chest result negatively. These patients never look very ill. After a varying length of time, the presence of fluid under the diaphragm, and perhaps, also, in the pleural cavity is discovered by means of physical examination and the exploring needle. When the subphrenic abscess contains gas the diagnosis is generally more easy because of the obliteration of the liver dullness by full tympanitic resonance and because of the presence of succussion sounds. When it does not contain gas the question may arise whether one has not to deal with an effusion into the right chest. Most of the errors in diagnosis that have been made have been along this line. Three conditions are possible: there may be an effusion into the pleural cavity or there may be both a subphrenic and a pleural effusion or there may be a subphrenic effusion alone. The differential diagnosis must rest on the fact that when there is a well marked effusion under the diaphragm there are usually no thoracic symptoms; the upper level of the dullness is a straight line or is convex upward; there is little change in the line of dullness with a change in the position of the patient. While in a pleural effusion the respiratory murmur is much diminished or absent below the level of the fluid, in subphrenic effusions the murmur can generally be heard plainly below the level of the fluid.

Depression of the liver is frequent in subphrenic abcesses; it is rare in pleurisy unless the effusion is a very large one. The heart is never appreciably pushed to the right nor are the intercostal spaces

bulged out in effusions under the diaphragm. If pus is withdrawn by aspiration through one of the lower intercostal spaces and clear fluid by aspiration higher up, the diagnosis of association between the two conditions is almost assured. When perforation of the diaphragm occurs it is characterized by the sudden appearance of symptoms of invasion of the pleural cavity—cough, rapid respiration, expectoration and frequently rapid collapse.

The differential diagnosis between subphrenic abscess and abscess of the liver is often very difficult and sometimes impossible before operation. Abscess of the liver is, however, much more rare after appendicitis than is subphrenic abscess. Pain in the right shoulder blade is rare in subphrenic cases and frequent in abscess of the liver. Paralysis of the diaphragm, and hence diminution or absence of respiratory movements of the liver, occurs far more often in subphrenic affections. Chills and profuse sweats are more frequent in abscess of the liver.

The final and positive diagnosis must be made with the aspirating needle, the puncture being made in the seventh to the tenth intercostal space in the axillary line, unless there are signs of pointing in front or lumbar region. Fluid obtained by aspiration should be always examined for liver abscess. The characteristic pus of liver abscess is of a light chocolate color with little or no odor. Foul odor of the pus will generally mean subphrenic abscess and not liver abscess, although the possibility of an hepatic abscess which has ruptured into the subphrenic region must be remembered. The method of treatment by Elsberg is as follows; about two inches of the ninth and tenth ribs are resected between the scapular and anterior axillary lines according as the exploring needle locates the pus anteriorly or posteriorly. The two ribs can be resected through one incision made in the intercostal space between them. After the ribs have been resected, the diaphragm with the liver showing below it will appear in the lowermost portion of the wound, and the pleural reflection will be seen in the upper part.

If there is suspicion that the pleural cavity contains pus, aspiration of the pleura should first be done. If pus is obtained the cavity should be opened and drained at once. If aspiration of the pleura is deemed unnecessary or inexpedient (as is generally the case) the upper part of the wound should be carefully protected with gauze and the aspirating needle then made to perforate the diaphragm below the reflection of the pleura. If the needle enters the abscess cavity it should be allowed to remain in place and be used as director. A small incision of the diaphragm alongside the needle, the dilatation of the small opening

with the dressing forceps, and the drainage of the abscess cavity with tubes according to general principles, are all that is required. The abscess cavity may, however, be situated so near the median line high up under the dome of the diaphragm that it can only be reached by the trans-pleural route. The pleural cavity can then be opened without further delay through the upper part of the wound. In some cases the costo-phrenic sinus has been entirely obliterated by adhesive inflammation so that the pleura can be incised without opening the pleural cavity proper. If this is the case great care must be taken not to tear the adhesions as they are often very weak and easily separated. If the pleural cavity must nevertheless be opened it should be done as rapidly as possible. By means of upward pressure against the liver it is often possible to so closely approximate the diaphragmatic to the costal pleura that little if any air can enter the pleural cavity when the opening is made. Sometimes it is impossible to unite the two pleural layers by suture and all that can be done is to wall off the cavity carefully with antiseptic gauze.

SENT TO A PATIENT, WITH THE PRESENT OF A COUPLE OF DUCKS.

I've dispatch'd, my dear madam, this scrap of a letter,
To say that Miss ———— is very much better.
A Regular Doctor no longer she lacks,
And therefore I've sent her a couple of Quacks.

—Dr. Edward Jenner.

REMARKS ON THE DIAGNOSIS AND TREATMENT OF SYPHILIS.

By JAMES ROSS, M. D.,
Vice-President Halifax, & N. S. Branch B. M. A.
(Read before the Association, Feb. 14th, 1906.)

WHEN our President with his usual persuasive power—this inmate characteristic of his has many times been referred to—asked for a contribution to the programme during the present session, it was with difficulty that I could decide on a subject interesting and instructive to the members. However, it was evidently compulsory to inflict myself on this gathering, a prerequisitive of the high office to which you so kindly elevated me at the last annual meeting.

The subject of this paper, if attempted to be treated exhaustively, would entail time beyond the limits of this and many other evenings ; but to allay your fears, I wish to put emphasis on the first word of the title, and thereby assure you that early retirers may have no anxiety in being detained beyond their customary hour.

My remarks this evening will briefly allude to several points in the diagnosis and treatment of syphilis, gathered from the teachings of authorities, and the limited experience of the reader.

DIAGNOSIS : First, I will refer to theinitial lesion. You are all familiar with the description of the typical chancre : first a papule followed by ulceration, rarely deep, sloping towards the centre, edges sloping, secretion scanty, floor red, livid or copper-coloured, induration firm or cartilaginous, practically painless. Now in rare cases of chancre, induration appears to be entirely absent. This, however, may sometimes be due to careless examination or to its co-existence with chancroid. It is peculiar that a typically indurated chancre is a rare thing in women, thereby spreading contagion in many cases where the patient is unaware of her trouble.

The initial lesion is nearly always single, but may be multiple. This I have seen: in one case where two typical indurated chancres were situated on opposite sides of the corona ; in another case, a female, three lesions were present, followed by severe secondary symptoms. In the latter case there was the possibility of mixed infection, there being only slight induration. The ingestion of mercury, however, soon caused the ulcers to vanish, which had been present for several weeks preceding treatment. In my cases I have met with a urethral chancre but once. The first symptom was a thin

discharge occurring about three weeks after intercourse. There were no gonococci found on microscopical examination and there was no history of a previous gonorrhœa. The indurated glandular enlargement was soon manifest and the induration distinctly felt about an inch from the meatus after two weeks' observation, followed by the roseola and sore-throat. The extra-genital chancre is not an uncommon occurrence. This may be seen upon any part of the body, although most frequent upon the face, particularly the lips. I have seen it on the lips several times, on the tongue once, and in one case it was situated on the back over the scapula.

As a complication of hard chancre, Lydston mentions herpes preputialis as a frequent occurrence. This I have met with on many occasions, and it may not be out of place here to warn the practitioner of the possibility of diagnosing herpes as chancroids. On one occasion I was about to cauterize a group of herpes situated around the corona, which on closer inspection changed the diagnosis to herpes of an irritable and severe type. There is also the possibility in the diagnosis of herpes to overlook the existence of a hard chancre, which happened in one instance at least in my experience on the first examination.

THE MACULAR SYPHILIDE: This is usually the earliest and most common cutaneous manifestation, appearing six or eight weeks after inoculation. It is generally distributed on the sides of the trunk, the umbilical region and the flexor aspects of the arms. The diagnosis is usually easy, since it is commonly associated with other syphilitic manifestations, such as a few scattered papules, sore throat, mucous patches and the chancre usually still present.

THE PAPULAR SYPHILIDE: This eruption presents several varieties which I will not here enumerate. One point, however, I would particularly emphasize is the fringe-like collar of epidermis, which is sometimes found on scattered papules in the eruption, appearing as if the individual papule had pushed itself through the epidermis. This feature was pointed out to me by Dr. Morgan Dockrell when attending his clinic at St. John's Hospital for Diseases of the Skin, London. Lydston in his work likewise alludes to this peculiar appearance which he refers to as "The Collarette of Biette." This is supposed by some to be pathognomonic of syphilis, but unfortunately it is often absent. Many times, however, has this picture been a great aid to me in the diagnosis of a papular syphiloderm.

Some of the gentlemen present may have remembered a patient under my care at the hospital during the summer of 1904, who was

afflicted with a papulo-vesicular eruption, covering most of his body. This man, who was of large stature, was practically helpless on admission, and suffered considerable pain, as the skin was raw, and the exudation of large amount and offensive. He was unable to walk, as the spaces between his toes were fissured and covered with vegetations. This man had been to New York some some years previously, under the care of a skin specialist, who had several other eminent men to examine him. According to the patient's story, a diagnosis was not made, and no improvement resulted. The condition was evidently a rare one, and, needless to state, caused me considerable perplexity. There was no history of syphilis that could be obtained. A vesicular syphilide is a very rare manifestation, and many observers have never seen it. What gave me a clue to the eruption was the presence of scattered papules with the typical epidermic collar, referred to. He was put on mixed treatment, the iodide being increased slowly. He was in the hospital about a month, when he became homesick, and left the institution during my absence at the Canadian Association meeting at Vancouver. I was particularly interested in the case, particularly as I was promised a fast horse and nice light buggy should he recover under my treatment, though the patient was in a public ward. Dr. Freeman, then of New Germany, soon wrote me on his return, that there was little or no improvement in the patient's contion, and asked if I could suggest anything else. I replied to increase the iodide if necessary to large doses. This he did and the eruption soon began to fade with subsequent total recovery. I am still waiting for the 2.30 trotter.

The Papulo-Squamous Syphilide: Some of these cases bear a close resemblance to psoriasis and may easily be mistaken, if not examined critically.

An interesting case I saw at the hospital some years ago, in which the two conditions were present at the same time, as I pointed out at a clinic given to fourth year students. On mixed treatment the syphilitic eruption soon disappeared, but had no effect on the psoriasis. A marked case of a papulo-squamous syphilide I have already referred to in a short paper entitled "Case Reports of Syphilis, with Remarks," read before the Maritime Medical Association in 1903. My reason for mentioning this case again is to lay stress on the total unreliability of the history as given by many patients.

"A young lady, aged 26. First seen on May 13th of this year, (1903) complaining of a rash on arms, legs and body. The history, as given by the patient, was that about the 1st of March last a fine rash of a pinkish color appeared, affecting most of the body, which

was accompanied by much itching and burning. The spots gradually got larger and brighter, and the itching became more intense. The rash, when I first saw it, was very extensive, covering the arms thickly as a large papular rash, varying from a pea to a five-cent piece, and covered by grayish scales. Some on the back, which was also extensively covered, were even larger, but showing the same characteristics. The color was the well-know raw-ham shade. The palms of the hands also showed several discrete lesions having a punched-out appearance, but superficial, which is most characteristic of syphilis. There was likewise marked glandular enlargement present.

"The appearance of the eruption on the body might easily have been mistaken for psoriasis; but on careful examinatlon I found that the condition present was a papulo-squamous syphilide, which in some of the older books was termed "syphilitic psoriasis."

"This patient gave no history to throw further light on the subject. She evidently had some idea as to the nature of the trouble, but resented any suggestions as to the most probable way in which it was contracted. It had been diagnosed as eczema and also psoriasis, no suspicion of the real trouble ever entering the minds of the other two doctors who had previously examined her. And no wonder: here was a case much resembling psoriasis guttata, with a history of intense itching, but nothing further to clear up the mists of doubt. The complaint of itching I did not place much reliance on, and thought it evidently a blind to throw unsuspecting diagnosticians off their guard. However, I ordered an antipruritic lotion, which she said gave her much relief. Mixed treatment was also prescribed, and soon rapid improvement followed. When last seen, five weeks after starting treatment, the rash had disappeared, leaving nothing but slight pigmentation."

THE TUBERCULO-ULCEROUS SYPHILIDE: The scales of ulcerative syphilides are thick, rough and adherent, and usually of a greenish-black colour. They are sluggish like any chronic ulcer, painless, unless inflamed or where the periosteum is involved. The tubercular syphilide has a tendency to become serpiginous, ulcerating at the border with heaped-up crusts. Several groups may coalesce and in this manner the circle enlarges, leaving an atrophic area behind, which is often pigmented. This may be divided into the superficial and deep serpiginous syphilides.

About one year ago, a young man, who had suffered from an ulcerative eruption of the face, consulted me, though doubtful of ever becoming improvod. The fact was, he was ordered by his employer to ask my opinion, as he

rather objected having a clerk in his warehouse presenting such a repulsive picture. The patient, however, entertained little hope of cure, and no wonder, as he had already been under the care of two or three physicians, who evidently never dreamed of the nature of the eruption. Why? Simply because the man never had a chancre that he was aware of, or the usual symptoms of sore throat and alopecia. When I first saw him, the forehead presented a number of small scars, thin, rounded and non-adherent. There were two ulcerated patches covered with dirty dark-greenish crusts, below, and to the outer side of each eye, having a tendency to serpiginous spreading.

The diagnosis was not difficult, and mixed treatment soon caused a rapid termination to his unsightly appearance. On subsequent questioning, he gave me the information that a few months before the eruption started, he had what he considered a small boil on the side of his face, which took many weeks to vanish. It started from a slight cut by a razor while being shaved in a town of this province.

It is not my purpose to criticize those who failed to diagnose the condition present, as every one of us is liable to error. But on the other hand a practitioner who keeps a patient "on a string" for long tedious months, endeavouring to treat a disease which he cannot diagnose, is, to put it mildly, doing the patient a great injustice.

This, Mr. President, is not an instance of "sour grapes" from a monetary standpoint, for the professional services rendered brought me in considerable more cash than the ordinary consultation fee. A consultation would, however, have saved the rather forcible uncomplimentary terms of the long-suffering patient against his former medical attendants.

When syphilitic ulceration attacks the nose it is very important that the diagnosis should be made early, owing to the rapidly destructive process caused by the disease. There is at present in the hospital a young girl, fifteen years of age, in whom the septum of the nose is almost completely destroyed, and on admission the whole upper lip showed a dirty sloughing ulceration, well defined edges, with an offensive discharge. This condition began in the septum, about a year previously; before this process had developed the glands of the neck had been noticed swollen. The first symptoms of nasal trouble observed was a discharge from the nostril, with an offensive odour. Treatment has produced a marked effect in this case, but unfortunately, much time was lost previous to her admission to the hospital.

The diseases most likely to be confounded with this condition are epithelioma, more especially the rodent ulcer, and lupus vulgaris. Rodent usually begins late in life, and has a characteristic pearly

roll-like border. It frequently arises from a preexisting mole or wart, and in many cases its course is particularly slow.

Lupus often bears a close resemblance to the tubercular syphiloderm. The ulcerations of syphilis may be superficial or deep, those of lupus almost uniformly shallow. Usually discharge is abundant in the former, whereas in lupus it is as a rule scanty. In syphilis the bone may become involved in the destructive process; in lupus this is rarely if ever seen. In syphilis scar formation is usually soft, in lupus it is often dense, thick and tough.

There is one peculiar feature of syphilitic eruptions that is often of diagnostic value, that is, the syphilides appear more prominent when inspected at a moderate distance than when the patient is near the eye. Lydston places considerable value on this point. He says: "When an eruption of syphilis is more or less blurred and indistinct, as, for example, when mixed with acne, the patient should be asked to step away ten to fifteen feet. It will be found that while the simple eruption becomes fainter, the syphilitic lesions stand out in bold relief, and appear larger than when near at hand."

TREATMENT: It is hardly necessary to remark that the physician should always wait until his diagnosis is sure in case of early syphilis. No man should begin a mercurial course until he sees more than the chancre to fortify his diagnosis. It is essential that secondary symptoms must be in evidence before merging on the long course necessary to eradicate the disease. The grey powder, with or without a small proportion of Dover's powder, which is convenient in tablet form, has for some years been my favourite prescription—the form of mercury so highly extrolled by Hutchinson and others. The protiodide so much in vogue, never seemed to meet the needs and I practically never prescribe it. A solution of biniodide of mercury in an aseptic oil, known on the market as "cypridol," has been highly recommended by a number of French physicians, but my experience with it is rather too limited to state an opinion. In several cases, however, it seemed to answer admirably where the patient had tired of the grey powder.

In a case of gumatous ulceration of the tibia, which I mentioned at a previous meeting, I gave six drams of a saturated solution of potassium iodide with a dram of syrup trifolium compound, three times a day, before any benefit resulted. The patient was a thin, delicate looking subject, weighing only one hundred pounds, but this enormous dose did not disturb his digestion in the slightest degree. This was the patient in whom the chancre made its appearance over the region of the scaupla.

For over a year I have treated syphilis by the intramuscular injection of salicylate of mercury, with very satisfactory results. The details, as advocated by Dr. Gottheil, have been followed in nearly every particular. The salicylate is suspended in sterilized albolene, and the injection given in the gluteal region, on the average every week for two or three months, and subsequently less frequent. The dose of salicylate given is one-half to one grain, but in exceptional cases this may be considerably increased and given at shorter intervals.

The patient is kept more under control by this method of treatment and is not inconvenienced by the necessity of swallowing drugs. The benzoate and lactate are other salts of mercury likewise advocated for subcutaneous injection.

References—Julien, International Clinics, Volume IV, Thirteenth Series; Gottheil, Volume III, Fourteenth Series.

ATMOSPHERIC HUMIDITY IN RELATION TO HEALTH.

By A. P. REID, M. D., L. R. C. P., Etc., Provincial Health Officer, Middleton, N. S.

(Read at meeting of Canadian Medical Asssociation, Halifax, August, 1905.)

A WANT of definiteness in the ideas that prevail on this subject must be my excuse for introducing this paper to your notice.

Trusting to your forbearance, and in order to prevent repetition and argument, I will mention a few physical laws.

First :—The capacity of the atmosphere to retain or absorb vapor of water at the freezing point is practically nil; with increase of temperature is increased ability to retain vapor, which goes on in an expanding ratio, so that at 80° F. it can absorb a very large amount. It is like a sponge with water; compressed it may be nearly dry, but as it expands it can absorb proportionally. Increasing the temperature of the air increases its absorptive capacity, and conversely lowering the temperature diminishes it, hence we have what is called the dew-point, which varies owing to the temperature, and the humidity or amount of vapor in the air.

Second :—Normal humidity generally runs from 60% to 70%, marked divergence from which is apt to cause a feeling of depression and a tendency to disease. In the open air the normal condition generally prevails, because as the temperature rises and falls so does the humidity. An artificial atmosphere, unless special provision be made, has not this power to

correct abnormality. Hence outside air is esteemed healthful and the confined air of the house is often the reverse. There are of course other contributory agencies such as dust, but dust may be, and often is very plentiful outside, and the microbes are also very evenly distributed be it winter or summer.

Third:—The vital processes generate a superabundance of heat and this must be dissipated, and the chief agency in carrying this out is the insensible evaporation of water (which becomes sensible when there is an excessive demand for this function), because the conversion of water into vapor absorbs a great amount of heat. The surface of the skin and the moist surface of the mucous membrane of the air passages are the chief means for the removal of this extra heat. By our clothing we can and do modify the influence of the skin, but we cannot so modify the function of the mucous membrane. The work it does is more pronounced than that of the skin owing to the great extent of its surface and of the moisture with which it is always covered, *hence it is easy to perceive that anything which interferes with or modifies this function may pro rata interfere with health. Either by debilitating the sytsem from the greater demand on its vitality, giving rise to various forms of malaise, or if there be a contagious element present it may find a fitting nidus for its growth, the debilitated system being unable to counteract its malevolence.*

Fourth:—Temperature (per se) is not a cause of disease, for perfect health is consistent (with an open air residence) from the heat of the tropics to the cold of the arctics, and this even with undue exposure as well as starvation.

There is reason to believe that respiratory diseases are not only more rife but more severe than formerly.

The winter season, which used to be inimical to the aged and weakly, is now almost as much so to the young and vigorous, pneumonia in the larger cities increasing as the cold weather develops, and decreasing as the season opens out to summer.

The costly residence with all the modern improvements and sanitary mechanisms, I think I am justified in saying, has not less but more sickness amongst its inmates than the old fashioned domicile with many insanitary surroundings, poorly heated, and with no ventilation except what gets in by leaky doors and windows and a big fireplace; where flakes of snow can settle down on the restless sleeper; and where cold draughts play in every corner.

Were I to ask what causes the common cold (not of a serious character), which few people pass a winter without suffering from more or less, the response would be more in what it did not say than what it did. Germs floating in the air, attacking a person debilitated from some cause (for the

germs are always present more or less), would be the most appropriate answer. But why is a person in good ordinary health attacked when there is no sufficient reason apparent?

In the normal atmosphere, whether cold or warm, wet or dry, under excessive fatigue alone, or with hunger added, with wet feet or chills, and with the germs as usual in the atmosphere, disease may not be contracted by a party so exposed even when he may be debilitated in various ways.

What can be the explanation for these contradictory conditions? Evidently the cause must be one that is very generally distributed, which acting in conjunction with others can thus initiate disease.

Respiratory diseases are by far the most common, and I think there can be included amongst these not only the ordinary ones affecting the lungs, bronchi, larynx, throat and nose, but measles, scarlet fever, small-pox, chicken-pox, and even typhoid fever, as the bronchial mucous membrane is likely to be involved in all these affections. Bearing these facts in mind it does not seem to be a far stretch of the imagination to assume that some cause acting on this membrane may be a determining cause. Temperature may be excluded as only contributory, and reasoning by exclusion, *atmospheric humidity*.

To understand how atmospheric humidity may be a determining cause, let us consider the subject. By clothing we adjust ourselves to the external temperature, but the very large evaporating surface of the respiratory mucous membrane is not in the same way under our control, and an abnormal condition of the atmosphere means that the vital powers are unduly taxed to make up the difference, and when this point has been overreached, and if any seeds of disease be present, then is the system unable to overcome the cause of disease and the malady supervenes. It is not difficult to conceive that a dry atmosphere is avid of moisture and an increased evaporation of water from the mucous membrane would lower the temperature unduly, and the system is called on to make up the difference in some other and not so easy a way; hence if this condition act for too long a time, disease results.

Assume the converse, a too humid atmosphere; then water will not evaporate from the moist membrane in sufficient quantity to low the temperature and lassitude very rapidly supervenes, and we complain of the close "muggy" atmosphere. In the acute form it gives rise to heat prostration and in a milder form to some of the other diseases that affect the debilitated.

It means also that a moist atmosphere at 60° F. or 70° F. feels warmer than a dry atmosphere at 80° F., or put in a more practical shape a normal 60% or 70% of humidity feels at 60° F. more comfortably warm than 75° F. or 80°F.

if abnormally dry. *This fact is very generally overlooked in the warming and ventilation of the modern house.*

If the above facts be correctly interpreted it means that, in our houses, halls, schools, churches and work-rooms, the hygrometer is necessary and the thermometer is rather ornamental than useful, because our ordinary sensations are as good guide as any as to the temperature. What form of hygrometer to use is a question?

The wet and dry bulb thermometer is the best, but it requires some attention and a little skill to read it aright. What is wanted is something that is easily interpreted and that will require no attention, and I have been working for some time on this subject, with a fair practical result. The effect of moisture on the chloride of cobalt is well known and often made use of under the name of a "barometer." There are many formulae used in making this indicator. The following I have found to be very satisfactory:

Calcium chloride,	34	parts.
Sodium chloride	15	"
Cobalt chloride	30	"
Gum Arabic	9	"
Water	90	"

Dissolve carefully, and then soak thin white muslin in it and wring as dry as possible, then hang up and allow to dry, then cut into convenient strips for use. When moist it is *pink or red*, and when dry it is *blue*. An atmosphere of 70% humidity or over gives a *reddish* shade, one 60% humidity or under a *blue* shade, so that a normal atmospheric moisture will give a *greyish* or *neutral tint*, neither red nor blue. Little strips of this muslin (like strips of test paper) can be hung up in all the rooms and halls and they will give most reliable information.

Paper can be used in place of muslin, but I do not think it is as good and it will not bear as much handling.

The next question is not so readily disposed of. With the ordinary means of heating, how are we to get the normal humidity? All the heating systems claim to supply this want, but there is no sufficient means of knowing whether they do or not. It is a sort of "hit or miss," without any system. A tank or reservoir is a part of the furnace which is supposed to be kept full of water; generally, however, it is dry or has a fitful supply, and there is no index to give notice when it is empty or whether it is properly performing its duty. Again, assume that it is working, how are we to know that it is right?

The whole thing looks like a "sop to Cerberus" (science), and so it goes, until the slaughter of the innocents causes investigation.

It would take much more water to supply our heating systems with sufficient moisture than is generally supposed; at least such is my experience. By accident I constructed better than I knew.

In putting in a heating system in my house I had to go down into the ground to get sufficient draught, so much so that the floor of the hot-air chamber was not only moist, but frequently had water in it. The floor was 18 x 6 feet, a very large evaporating surface. I also noticed that the hygrometer was nearly at the normal all the time.

Direct Radiation:—Let us consider some of our heating systems.

Hot Water:—Good for raising the temperature in the room, but the supply of moisture or fresh air is a matter of chance.

Steam Heat:—If distributed in the same way, has same defects.

Hot Air Furnace:—This is theoretically good, because it brings in fresh air, but there is not sufficient provision for moisture, and the air is apt to be heated too hot—to be dry, and harsh.

The Grate and Fire Place:—From a sanitary point of view are fairly good but comparatively a failure economically, and not efficient.

Indirect Radiation:—Theoretically good but practically no sufficient means are taken to add sufficient moisture so that there is a so called *burnt condition* of the air, similar to, but not so marked as in the hot air furnace system.

That we may try to understand what is meant by normal humidity, let us assume that we take air at 40° F. and normal, let it be raised to 70° F. it has only the moisture of 40°, and barely contains half of what would be normal at 70°, and this difference becomes greater as we go below 40° or above 70°. It is not to be wondered at that there is an increase of pneumonia and respiratory diseases, with our modern systems of heating, tight houses, and figurative ventilation

The method of heating is good, but it is in a crude and undeveloped form, due, I think, in part to the fact that hazy ideas prevailed and yet prevail as to the object which is to be attained.

The conditions referred to are really the offspring of a higher civilization and a more dense population, and there is no reason why we should not have as good sanitary conditions along with the increased comforts of living, as are obtainable with sparse populations, did we make practical our present knowledge. In the present war Japan has demonstrated to the world that the careful practice of our present sanitary information gives astonishing results. Working on the same lines our homes, schools, and work-rooms should be nearly as healthy as if they were in the open air.

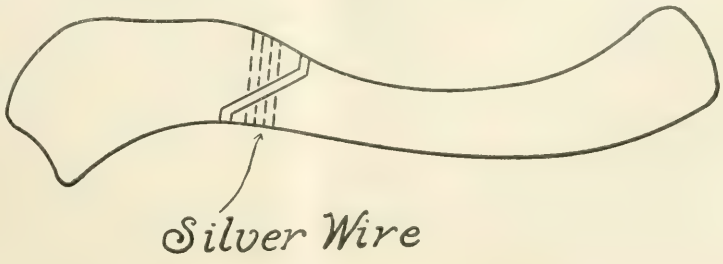
RECENT FRACTURE OF THE CLAVICLE WITH OPERATIVE TREATMENT.

Case Report by J. W. T. PATTON, M. D.,
Truro N. S.

(Read before Canadian Medical Association, Halifax, August, 1905.)

THE rarity of operative treatment of recent fracture of the clavicle, and the highly successful result obtained in a case so treated, is my excuse for reporting the following case :—

On September 1st, 1904, J. K. C., æt 56, consulted me for injury received that morning. While harnessing a horse in the barn he was jammed against the side of the stall by the animal, the point of the shoulder striking the wall. Upon examination, a fracture of the right clavicle was readily determined, the fractured ends overlapping. The patient was a large muscular man, and reduction of the fragments and maintenance of reduction was performed with much difficulty. Feeling certain that the fracture was an oblique one, and that reduction could be maintained with great difficulty, with probably considerable deformity and impairment of function, the question of operation was discussed with the patient and it met with his approval. Under chloroform, the fracture was exposed, and as suspected, it was somewhat oblique, as shown by the accompanying diagram.



The fragments were adjusted and held in place by encircling them with two or three strands of silver wire. The operation wound was closed with silk-worm gut sutures and the arm fixed to the chest by a Velpeau bandage. Recovery was uninterrupted and rapid. The sutures were removed on the fourth day and the bandage was replaced and maintained for two weeks more, after which the arm was kept in a sling for another week.

The subsequent history was uneventful. The patient began slight movements of the arm after the bandage was removed, and these he gradually increased. In response to enquiry regarding the condition of his shoulder, the patient always replied, "My arm feels better and stronger every day." The last enquiry a few weeks ago elicited the response, "I can't tell any difference from the other arm."

It might be questioned whether it were wise thus to convert a simple into a compound fracture. In considering the subject pro and con, I

felt it would be justifiable for the following reasons :—(1) There was considerable deformity which could not be held reduced ; (2) The patient was a laboring man and was anxious that there should be little or no interference with the subsequent use of his arm ; (3) He was desirous that recovery should be as rapid as possible.

I think that the result has justified the treatment adopted. When contrasted with the usual treatment of fractured clavicle by one of the various non-operative methods, one is struck with the rapid recovery of function and strength, (I met the patient driving into town on September 22nd, and he has used his arm more or less from that date) the small amount of callus, and the entire absence of deformity.

Scudder* says of the operative treatment of fractured clavicle—in recent fractures : "If there is great deplacement which cannot be held reduced, if sharp fragments threaten vessels or nerves, if there is pressure upon either nerves or blood-vessels, if the fracture is a comminuted one, and if the bone is fractured in two or more places, it is wise to consider operative measures.'

In ununited fractures :—" If the cause of delayed union of the fractures is a misplaced bony fragment, an interposed strip of fascia or periosteum, or an interposed subclavius muscle, operative interference may be undertaken with a reasonable expectation of securing a good result."

* " The Treatment of Fractures," Scudder

SOCIETY MEETINGS.

British Medical Association.

(Halifax and Nova Scotia Branch.)

MARCH 14TH, 1906.—The Branch met at the City Council Chamber. On motion of Dr. Eagar a committee was appointed to consider the question of compulsory registration of births in the city of Halifax.

On behalf of the committee appointed to investigate and report upon the model tenement proposition, Dr. Goodwin moved a resolution strongly supporting the scheme, which carried unanimously; and a copy of it was ordered to be sent to Rev. Dr. Armitage who had placed the question before the Branch.

Dr. L. M. Murray moved that a committee be appointed with a view to securing any necessary legislation regarding patent medicines.

Dr. Ellis, M. P. P., spoke in favor of such legislation, giving it as his opinion that the matter under discussion was within the jurisdiction solely of the provincial legislature. The motion was passed and a committee named.

Dr. G. L. Sinclair read a short paper, "The Medical Aspects of Hypnotism," following it with a series of most successful demonstrations of hypnotic phenomena, using as subjects several of the gentlemen present. Interesting discussion followed this paper, after which a vote of thanks to Dr. Sinclair was tendered.

New members elected by Branch Council:—Drs. Duncan Campbell, W. A. Christie, I. E. Dyas, G. W. T. Farish, D. Mackintosh, E. O. Macdonald, J. C. MacDonald, S. J. McLennan, J. P. C. McManus, John McNichol, Freeman O'Neil, R. B. M. Wiley, T. F. Sprague, D. A. Taylor, A. J. Murray, G. C. VanWart.

MARCH 28TH, 1906.—The Branch met at the Halifax Hotel.

The committee on birth registration reported, recommending that a committee be appointed to present the views of the Branch to the City Council. On motion, this was done.

Dr. Kirkpatrick brought it to the attention of the Branch that certain practising opticians in Halifax had been prescribing eye-drops and ointment in certain cases. After some discussion a resolution was passed condemning such practices and deciding that the cases mentioned be brought to the notice of the Provincial Medical Board, a committee being appointed for that purpose.

Dr. Kirkpatrick read a paper "Nasal Obstruction, its effects, prevention and cure." (This paper will be published in a later number.)

Dr. Kirkpatrick's paper called forth considerable discussion as to the essential factors involved in "taking cold," and especially in acute coryza.

Dr. Eagar read a paper "Congential Hypertrophic Pyloric Stenosis." He claimed that this condition was considered rare, only because most cases are undiagnosed,

that it was really responsible for a good many of the cases of "marasmus," so-called.

New members elected by Branch Council:—Drs. Peter McLaren, F. H. Wetmore, W. H. Irvine, B. S. Price, R. L. Ellis, F. W. Green, D. J. MacDonald, J. Ross Millar. Dr. T. J. A. Cochrane was re-elected to membership.

APRIL 11TH, 1906.—The final meeting for the year 1905-06 was held at the City Council Chambers.

Reports of Committees:—The committee on birth registration, through Dr. Eagar, reported that the City Council was interested in the question and that they had reported it to the laws and privileges committee. After adoption of this report the committee was continued in power, that they may co-operate with the similar committee of the Medical Society of Nova Scotia.

Dr. Stewart, on behalf of the committee on patent medicine legislation, reported that the Bill relating to this subject had passed its second reading in the legislature.

Dr. A. P. Reid informed the Branch that the proposed amendments to the Health Act were meeting with favorable progress in the legislature.

The programme for the evening after the conclusion of business included an exhibition by Dr. Stewart of Luy's segregator. Dr. Stewart explained the uses of this instrument and stated his experience with it.

"A Discussion on Physical Deterioration," taken part in informally by Drs. A. P. Reid, Murphy and others, concluded the programme for the evening and for the year.

New members elected by Branch Council:—Drs. Alex. MacNeil, C. S. Morton, M. T. McLean, Evan Kennedy, G. E. DeWitt, L. R. Morse, J. Hayes.

Organization of a Branch of the British Medical Association at St. John.

A meeting of the profession of St. John was held on 28th March for the purpose of considering the advisability of forming a St. John Branch of the British Medical Association.

There were present, Drs. Thomas Walker, S. Skinner, Berryman, J. H. Gray, G. A. B. Addy, Roberts, Inches, Kenney, James Christie, Bentley, Emery, McVey, McAlpine, Scammell, T. D. Walker, MacLaren, Ellis and McIntosh.

Dr. MacLaren acted as Chairman and Dr. Scammell as Secretary of the meeting.

It was unanimously agreed that the formation of a Branch was desirable, and those present signed a list to be forwarded to the head office, with an application for authority to establish a St. John, New Brunswick, Branch.

Other arrangements were also made with the view of facilitating the work.

Many names have since been received approving of the object and desiring to join the proposed branch, from all parts of province.

It is suggested that those who propose attending the Toronto meeting from New Brunswick, should arrange for a private car. All those who desire to form such a party are requested to send their names to the Secretary, Dr. Scammell, St. John.

CURRENT MEDICAL LITERATURE.

CHRISTIANITY AND SEX PROBLEMS. By HUGH NORTHCOTE, M. A. Crown Octavo, 257 Pages. Bound in Extra Cloth. Price, $2.00, net. F. A. DAVIS COMPANY, PUBLISHERS, 1914-16 Cherry Street, Philadelphia, Pa.

Books dealing with sex problems have multiplied rapidly of late, and some of them are of such a nature that they deserve nothing but condemnation. The title given to the book under review perhaps accounts for the fact that the reviewer began its reading in a decidedly antagonistic spirit, feeling that it doubtless merited a "scorching"—and that it would get it. But the work has proved to be a reverently and carefully thought out disquisition upon the relation of the sexual instinct to morality, and is assuredly entitled to considerate study by those who are called upon to deal with problems which have their basis in sexual relationships. The author evidently holds deeply rooted religious convictions, but he is withal a scientist, and has permitted no bias to distort his judgments. He deals fairly and clearly with the great variety of topics which open out for discussion in connection with his subject, and impresses the reader with the earnestness of his desire to set forth practical suggestions for the moral betterment of the race. We cannot help feeling, however, that there is no real need for such books, and that the danger of having them fall into the hands of the immature is not compensated by the good they might theoretically accomplish.

THE EXAMINATION OF THE FUNCTION OF THE INTESTINES BY MEANS OF THE TEST-DIET. Its Application in Medical Practice and its Diagnostic and Therapeutic Value. By PROF. DR. ADOLF SCHMIDT, Physician-in-chief of the City Hospital Friedrichstadt in Dresden. Authorized Translation from the latest German Edition, by CHARLES D. AARON, M. D., Professor of Diseases of the Stomach and Intestines in the Detroit Post-Graduate School of Medicine; Clinical Professor of Gastro-enterology in the Detroit College of Medicine; Consulting Gastro-enterologist to Harper Hospital, etc. With a frontispiece Plate in colors. Crown Octavo, 91 Pages, Extra Cloth. Price, $1.00, net. F. A. DAVIS COMPANY, Publishers, 1914-16 Cherry Street, Philadelphia.

This work is extremely interesting and practical. The author goes minutely into the results obtained in different disorders of the intestines by an examination of the fæces after the administration of a fixed diet for several days.

Though the apparatus is very simple, and Dr. Schmidt claims that the examination requires but a short time, still the lack of a proper laboratory or place to conduct the examination, will prevent the general use of such methods. There is, however, a growing tendency to specialize, and this class of work will fall to his lot or that of the bacteriologist.

I think that the majority of us after perusing Dr. Schmidt's work, will examine, or have the fæces examined more frequently in the future, as much light is thereby thrown on many of our obscure and troublesome intestinal diseases.

THE PHYSICAL EXAMINATION OF INFANTS AND YOUNG CHILDREN. By THERON WENDELL KILMER, M. D., Adjunct Attending Pediatrist to the Sydenham Hospital; Instructor in Pediatrics in the New York Polyclinic Medical School and Hospital, New York; Attending Physician to the Summer Home of St. Giles, Garden City, New York. Illustrated with 59 Half-tone Engravings. 12 mo., 86 pages. Bound in Extra Cloth. Price, 75 cents, net. F. A. DAVIS COMPANY, PUBLISHERS, 1914-16 Cherry Street, Philadelphia, Pa.

This little book is exactly what its name implies. The author does not deal with diagnosis or treatment, but enlightens us in a thoroughly systematic and practical manner on those subjects which are mentioned in the text books on pediatrics.

For the purpose of examination, he classifies the children according to their different temperaments, and instructs us how to deal with the different classes, in order to make our examinations profitable and easy.

Dr. Kilmer lays special stress on the weighing of infants in order to test the suitability of the baby's food. The technique of lavage; how to obtain the urine for examination, etc., etc, are also dealt with.

The book is beautifully illustrated with numerous photographic plates, showing the different methods of procedure in examining our little patients.

When we realize how prone the profession is to shirk those things which are disagreeable to the body, or trying to the temper, and how often we neglect or put off the examination of a child simply because it cries, the value of this work become apparent.

Though much in the book is well known to us it can be read with profit by all.

PERSONAL PARAGRAPHS.

DR. F. A. RAND has been elected mayor of Parrsboro.

The NEWS extends its sincere sympathy to Dr. D. A. Taylor, of Londonderry, in the death of Mrs. Taylor, which occurred suddenly while on a visit to Sydney.

Dr. A. P. Reid, our Provincial Health Officer, has lately been giving much appreciated instruction on the laws of health to the public Schools of Halifax and Dartmouth.

Dr. Ames, of Harbor Grace, was thrown out of his carriage last month and sustained severe injury to his spine and subsequent paralysis of the lower extremeties. Dr. Ames was taken to Montreal to undergo hospital treatment.

Dr. J. Howard Slayter has given up practice in Halifax and sold his residence to Dr. L. M. Murray. Dr. Slayter sailed on the last trip of the "Tunisian" and will study for two years in Germany.

Dr. F. U. Anderson is giving up practice for a few months on account of ill health, and will seek a much needed change.

Dr. R. King, who was assistant to Dr. Mader for a few months and later assistant physician on the medical staff of the Nova Scotia Hospital, has gone West to practice his profession there.

FOR IDLE MOMENTS.

A Watch in the Night.

THE Doctor's Wife (opening her eyes)—What! Going out again? It must be after one o'clock.

The Doctor (struggling into his vest)—Yes, just.

The Doctor's Wife—How dreadful! Wear your heavy overcoat; and, dear, please, will you mail that note. There, on the mantel?

The Doctor—Yes, all right.

The Doctor's Wife—And hurry, hurry back; for, oh, when you're away like this, at night, I never sleep.

The Doctor—You don't?

The Doctor's Wife—Why, no! What wife could calmly rest?

The Doctor—Ah, true.

The Doctor's Wife—So come straight home.

The Doctor—That's what I'll do; I won't stay out to view the sky, but try to doze, dear, meanwhile.

The Doctor's Wife (reproachfully) opening her eyes, after a silence—Do hurry and get off, for then you'll be the sooner back again; it is so lonely watching here.

The Doctor (taking off his necktie)—I've just been gone three hours, my dear.—*Doctor's Recreation Series.*

"Ma wants a package of dye and she wants a fashionable color." said a little girl to a druggist.

"A fashionable color? echoed the pharmacist. "What does she want it for; eggs or clothes?"

"Well," replied the girl, "the doctor says ma has stomach trouble and ought to diet. And ma says if she has to dye it she might as well dye it a fashionable color."

It is as easy to be great as to be small.

It's a wise chicken that knows its own incubator.

Christian Science Mamma: "He must imagine he has the colic."

Christian Science Papa: "I wish he'd imagine I'm walking the floor with him."

Harry, looking on when his little sister cried at being washed, turned away, saying: "If she screamed like that in heaven, I don't wonder they sent her down here."

Not Satisfactory.

Sandy was considerably run down, and submitted his case to the M. D. After a diagnosis, the physician said: "No red meat, no whiskey, and only one pipe a day." Sandy grunted, put on his bonnet and started out. "Wait," said the doctor. "You've forgotten something." "Fat micht that be?" asked Sandy. "My fee," was the reply. "Fee? Fat for?" asked Sandy. "My advice." "Hoot, mon," said Sandy, "A'll no be taken' yer domned advice!" and he stalked out of the room.—Controller Grout, in *N. Y. Globe.*

Why Not Peruna?

A man to whom illness was chronic,
When told that he needed a tonic,
Said, "Oh, doctor dear,
Won't you please make it beer?"
"No, no," said the Doc, "that's Teutonic."

A woman entered a photographer's gallery. "Do you take pictures of children?"

"Yes," was the reply.

"How much are they please?"

"Three dollars a dozen," said the proprietor.

"Well," she replied with a sigh, "I shall have to wait and come again, I have only eleven."

An Office Call.

Teacher.—Tommy, something has got to be done about your behavior. I think to-day after school I shall call and see your father.

Tommy.—It'll cost you $2 if you do. Pop's a doctor; office hours, 5 to 7.—*Puck.*

THE TALK OF THE OFFICE.

IT is a very great pleasure for us to receive a commendatory word from our subscribers, and we take a special—and, we feel, pardonable—pride in the subjoined letter. It has come from one of our veteran practitioners, one who has been for forty-nine years engaged in practice, but who is none the less active in spirit, energetic in body, studious, progressive and optimistic—a cheery stimulus to many men younger in years but less buoyant in temperament.

"In these days, when progress is the watchword, it is refreshing to receive our MARITIME MEDICAL NEWS in a brand new costume of the latest style. While the dress is much improved, it is satisfactory to note that the contents are still kept up to the high standard marked out by our much esteemed editors. As the MARITIME MEDICAL NEWS is exclusively the journal of the profession, it becomes the duty as well as the privilege of every well-wisher of the profession to assist in every legitimate way to make it a grand success from every point of view. It is not open to any member of the profession to find fault: if he sees a fault or a flaw, it is his duty to go in and mend it, improve upon it. By acting upon this principle the MARITIME MEDICAL NEWS will become as nearly perfect as possible. Any fool can tear down, can obstruct; but it requires brains, patience and perseverance to build up.

"The NEWS has become a necessity to the protession of the Maritime Provinces. Of late years the different medical societies have become the source of marked improvement in our profession. They have been the means of bringing the members of the profession more into contact, thereby becoming better acquainted, and thus stimulating each other to loftier ideas, professionally and ethically. Without our own MARITIME MEDICAL NEWS the benefits resulting from our conventions would be very much curtailed. The younger members of the profession are not in a position to appreciate the benefits which have resulted from the meetings of the different associations, to the same extent as one who has been attending them for the past thirty years, or one who has seen our Provincial Association grow from twenty or twenty-five, to what we are accustomed to see now at our annual meetings. They have been the agents for working a revolution in the profession. In conclusion I would urge upon the medical men, especially the young men, that it is their duty to themselves as well as to the profession, so far as possible, to attend the different society meetings, and in order to get the full benefit to be obtained by attending said meetings, that they contribute both brains and cash to keep the MARITIME MEDICAL NEWS in the honourable position already attained."

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A cleanly, convenient and very palatable method of administering Lactopeptine, especially for ambulant patients.

The tart, pineapple flavor, renders these tablets as acceptable as confections. They are particularly valuable as "After Dinner Tablets," to prevent or relieve pain or distension occurring after a heavy meal.

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DOSE--One to two tablespoonfuls three to six times a day.

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Formaldehyde, 0.2 per cent.
Aceto-Boro-Glyceride, 5 per cent.
Pinus Pumilio, Eucalyptus, Myrrh, Storax, Benzoin, } Active balsamic constituents.

SAMPLES AND LITERATURE ON APPLICATION.

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Amor's Essence of Cod Liver Oil (Plain)
Amor's Essence with Tincture Iron and Creosote
Amor's Essence with Terpin Hydrate and Codeia
Amor's Essence with Syrup Ferri Phos. Co
Amor's Essence with Syrup of Squills
Amor's Essence with Wild Cherry and Ipecac
Amor's Essence with Malt
Amor's Essence with Tinct. of Iron
Amor's Essence with Arsenic

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THERAPEUTIC NOTES.

Selective Action of Sanmetto on Genito-Urinary Apparatus.—Dr. J. T. Newman, of New Orleans, La., in a paper on "The Selective Action of Sanmetto upon the Genito-Urinary Apparatus," says: "I have used this remedy (Sanmetto) in all forms of cystitis and other affections of the urinary apparatus, but I desire more particularly to call attention to its value in chronic prostatitis, which occurs more especially among old men; and I can truly say, without exaggeration, that in my hands it has especially selective action upon the prostate. I am sure that any medical man, who will give Sanmetto an impartial trial, will become convinced of the truthfulness of this assertion."

Abnormal Mental Strain at Age of Puberty.—To young girls arriving at womanhood, many times laboring under abnormal mental strain from over-study and from the additional nervous tension due to the physical changes incidental to the first menstruation, Hayden's Viburnum Compound is particularly serviceable. It is a uterine sedative and calmative and assists in the normalization of the pelvic circulation. Hayden's Viburnum Compound has stood the test of time and for twenty-five years has been accepted and recognized as the standard remedy in the treatment of Dysmenorrhea, Amenorrhea, Menorrhagia and other diseases of the uterus and its appendages. To assure results the genuine Hayden Viburnum Compound only should be administered. Literature will be sent on request and sample, if express charges are paid, by the New York Pharmaceutical Co., Bedford Springs, Mass.

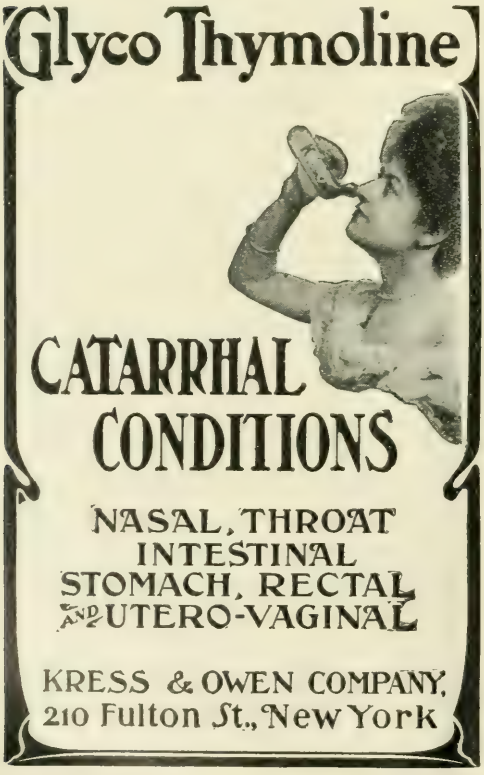
Spraying for Diseases of the Respiratory Passages.—Dr. David Walsh, senior physician to the Western Skin Hospital, London, writes: "Glyco-Thymoline was brought to my notice as an excellent lotion for nasal and oral sprays and washes. On due inquiry it was found to fulfill the two conditions usually recognized by medical men in the United Kingdom as vouching for the character, so to speak, of such a preparation. First, its advertisements are accepted by our three leading journals, the *Lancet*, *British Medical Journal* and the *Medical Press and Circular*. Secondly, its composition is not a secret, its formula being freely published. Under these circumstances, I determined to try the effect of this preparation in a few suitable cases. As a general antiseptic fluid that does not coagulate albumen, and is non-irritating, deodorant and practically non-poisonous, Glyco-Thymoline has clearly a wide range of usefulness. My own observations, however, have been practically confined to its use in the nose and mouth, with results that have proved satisfactory in every instance, especially in acute coryza, pharyngitis, influenza and septic conditions of the mouth."

Oil in Typhoid Fever.—Gneftos seems to have successfully treated typhoid along the line of preventing absorption of toxins through the walls of the intestines. To this end he gives small, repeated doses of some bland oil, intending so to coat the lining that it will be impervious to the toxins. He reports that since adopting this method of treatment he has not had a death in the sixty cases treated.—*Grece Medicale.*

Calcium Chloride in Postoperative Nasal Hemorrhage.—Reynold Webb Wilcox reports a striking example of the brilliant results from the use of what Wright has designated the "physiologic styptic" in a case of uncontrollable hemorrhage. Although the physiological demonstration was made in 1894 it has attracted but little attention in this country. The author endorses the results of laboratory experimentation that calcium chloride increases the fibrin in the blood and the coagulability.—*American Medicine.*

For Inhalation in Whooping-Cough.—Creasote, 3 drams; Eucalyptol, 2 drams; Spts. Chloroform, 6 drams; Terebene, add to 3 ounces. Fifteen drops on sponge wrung out of hot water.—Dr. BENJAMIN EDSON, Brooklyn.

Follicular Tonsillitis.—Formaldehyde, 20-30 minims; Glycerine, 2 ounces. Apply with a brush three or four times a day.—JORDAN.



THE TREATMENT OF NASAL CATARRH

BY

JOHN A. HALE, M.D.

Alto Pass, Ill.

FOR years I used various remedies and met with varying success, until tiring of one remedy after another I relied solely on Potassium Permanganate in weak solutions as a nasal douche, but a review of some points in this paper will show why I always sought for something else. Glyco-Thymoline has usurped the place of the permanganate solution in my armamentarium, and after sufficient trial, established faith, implicit faith, in its specific therapeusis for this condition. A knowledge of its essential constituents and their therapeutic action only tends to strengthen a belief in its specificity. Caution is necessary in the selection and use of remedies, but a fair trial has proven no untoward inconvenience emanating from the use of this remedy. Meanwhile the therapeutic results are gratifying and the good effect of Glyco-Thymoline can be easily verified by a trial, when conclusions will be the result of practical truths only.

3 AGES OF WOMEN

For young girls arriving at womanhood, many times laboring under abnormal mental strain from over-study, and from the additional nervous tension due to the physical changes incidental to the first menstruation

Hayden's Viburnum Compound

IS PARTICULARLY SERVICEABLE.

It is a uterine sedative and calmative and assists in the normalization of the pelvic circulation.

H. V. C.

has stood the test of time and for twenty-five years has been accepted and recognized as the standard remedy in the treatment of **Dysmenorrhea, Amenorrhea, Menorrhagia** and other diseases of the uterus and its appendages.

CAUTION—To assure results the genuine H. V. C. only should be administered. Literature sent on request and samples if express charges are paid.

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No Plaster Cast Needed.

A Positive Relief and Cure for FLAT-FOOT.

80% of Cases treated for Rheumatism, Rheumatic Gout, Rheumatic Arthritis of the Ankle Joint, are Flat-Foot.

The introduction of the improved *Instep Arch Supporter* has caused a revolution in the treatment of *Flat-foot*, obviating as it does the necessity of *taking a plaster cast of the deformed foot*.

The principal orthopedic surgeons and hospitals of England and the United States are using and endorsing these Supporters as superior to all others, owing to the vast improvement of this scientifically constructed appliance over the *heavy, rigid metallic plates* formerly used.

These Supporters are highly recommended by physicians for children who often suffer from *Flat-Foot*, and are treated for weak ankles when such is not the case, but in reality they are suffering from *Flat-foot*.

IN ORDERING SEND SIZE OF SHOE, OR TRACING OF FOOT IS THE BEST GUIDE.

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Faculty of Medicine, Seventy-Fourth Session, 1905 - 1906

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Thos. W. Walsh, M. D., Bell. Hosp. Med. Coll.; Adjunct Professor of Obstetrics.
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E. H. Lowerison, M. D., Lecturer on Ophthalmology, Otology, Etc.
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A. S. Mackenzie, Ph. D.; Prof. of Physics at Dalhousie College.
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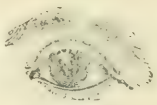

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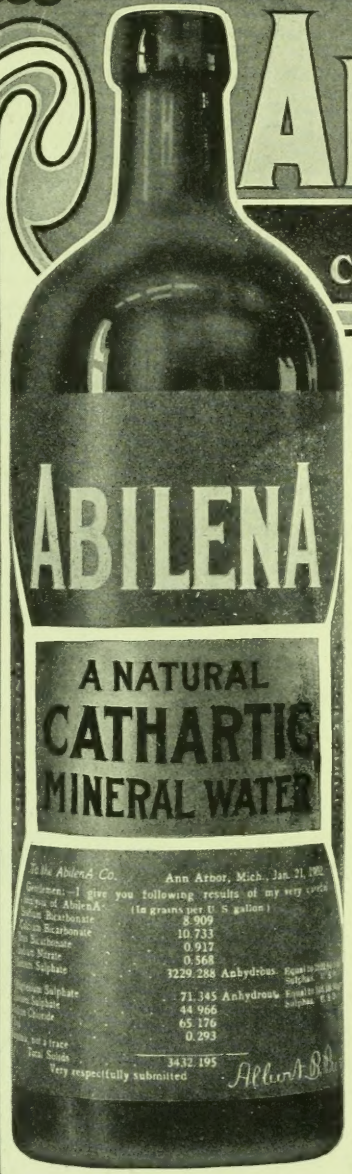

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